STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 01 B. WING	08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA STREET CARMEL, IN46032

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/17/11 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Manor Care Health Services Summer Trace was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type I (332) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and all resident sleeping rooms. The	K0000	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	facility has a capacity of 93 and had a census of 76 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 4 of 6 doors on the first floor serving hazardous areas such as the kitchen and storage rooms greater than fifty square feet in size used to store combustible materials are each equipped with self closing devices which cause the door to close and latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity the first floor kitchen and the first floor nursing supply room.	K0029	K 029 SS=E NFPA 101 Life Safety Code Standard It is the practice of this center to comply with K 029 NFPA 101 Life Safety Code Standard **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected. The 4 doors identified now self close and latch the door in to the door frame.	09/16/2011

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	Findings include: a. Based on observations with the Environmental Director and the Maintenance Director during a tour of the facility from 12:35 p.m. to 2:40 p.m. on 08/17/11, the northwest kitchen door to the corridor and the southwest and southeast kitchen doors to the dining room are each provided with a self closing device on the door, but each door is not provided with a positive latching device to latch each door into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the northwest, southwest and southeast kitchen doors are each not equipped with a positive latching device to latch each door into the door frame. b. Based on observation with the Environmental Director and the Maintenance Director during a tour of the facility from 12:35 p.m. to 2:40 p.m. on 08/17/11, the first floor nursing supply room measures 190 square feet and is used to store disposable briefs in cardboard boxes as well as other combustible nursing supplies, and is not equipped with a self closing device on the door which would automatically close and latch the door into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** No residents were affected. The 4 doors identified now self close and latch the door in to the door frame. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Staff has been re-educated that these areas must have self closing devices and latch the door in to the door frame. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Doors will be monitored weekly x 4 weeks by Environmental Services Director or Designee to ensure doors are still self closing and latching in to the door frame. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. **By what date the systemic changes will be completed;** September 16, 2011.	

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	the first floor nursing supply room measured greater than fifty square feet, is used to store combustible supplies, and is not equipped with a self closing device on the door. 3.1-19(b)			
K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 1. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 4 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Fire Alarm Report" documentation with the Environmental Director and the Maintenance Director from 9:30 a.m. to 12:05 p.m. on 08/17/11,	K0050	K 050 SS=C NFPA 101 Life Safety Code Standard It is the practice of this center to comply with K 050 NFPA 101 Life Safety Code Standard **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected. The Fire Drills will be conducted at unexpected times and varying conditions and a coded announcement will only be used	09/16/2011

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	nine of ten third shift fire drills conducted between 10/21/10 and 07/15/11 were conducted between 11:01 a.m. and 11:10 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b) 2. Based on record review and interview, the facility failed to document the transmission of the fire alarm signal for 2 of 2 fire drills conducted prior to 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Fire Alarm Report" documentation with the Environmental Director and the Maintenance Director from 9:30 a.m. to 12:05 p.m. on 08/17/11, documentation for two second shift fire drills conducted prior to 9:00 p.m. during the fourth quarter on 10/07/10 at 8:30 p.m. and on 12/15/10 at 5:16 p.m. did not		between 9pm and 6am and documentation will accurately reflect all Fire Drills conducted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** No residents were affected. The Fire Drills will be conducted at unexpected times and varying conditions and a coded announcement will only be used between 9pm and 6am and documentation will accurately reflect all Fire Drills conducted. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Staff has been re-educated that The Fire Drills will be conducted at unexpected times and varying conditions and a coded announcement will only be used between 9pm and 6am and documentation will accurately reflect all Fire Drills conducted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Fire Alarm Reports will be monitored Monthly x 3 months by Environmental Services Director or Designee to ensure that the Fire Drills are conducted at unexpected	

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	include the transmission of the fire alarm signal. Based on interview at the time of record review, the Environmental Director stated the fire alarm system was activated but acknowledged documentation of fourth quarter second shift fire drills conducted prior to 9:00 p.m. did not include transmission of the fire alarm signal.		times and varying conditions and a coded announcement is only used between 9pm and 6am and documentation accurately reflects all Fire Drills conducted. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. **By what date the systemic changes will be completed;** September 16, 2011.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for	K0144	K 144 SS=F NFPA 101 Life Safety Code Standard It is the practice of this center to comply with K 144 NFPA 101 Life Safety Code Standard **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected. The emergency generator will be equipped with a remote manual stop. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	09/16/2011

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	emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower of more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Environmental Director and the Maintenance Director during a tour of the facility from 12:35 p.m. to 2:40 p.m. on 08/17/11, no evidence of a remote shut off device was found for the 400 KW diesel fired emergency generator. Based on interview at the time of observation, the Maintenance Director stated the emergency generator was installed prior to 2003 and acknowledged there is no remote emergency shut off device for the generator. 3.1-19(b)		No residents were affected. The emergency generator will be equipped with a remote manual stop. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Staff has been re-educated that emergency generator will be equipped with a remote manual stop. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Emergency Generator Remote Manual Stop placement will be monitored Monthly x 1 month by Environmental Services Director or Designee to ensure emergency generator is equipped with a remote manual stop. The results of the audit will be submitted to the QA&A Committee for further review and recommendations. **By what date the systemic changes will be completed;** September 16, 2011.	